Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be reimbursement of $1,270.00 for dates of service 08/06/01 through 01/22/02.

   b. The request was received on 06/26/02.

II. EXHIBITS

1. Requestor, Exhibit I:

   a. TWCC 60
   b. HCFAs
   c. TWCC 62 form
   d. Medical Records
   e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:

   a. TWCC 60 and Response to a Request for Dispute Resolution
   b. HCFA(s)
   c. TWCC 62 form
   d. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on 07/31/02. Per Rule 133.307 (g) (4), the carrier representative signed for the copy on 08/01/02. The 3 day response from the insurance carrier was received in the Division on 06/18/02. There was no 14 day response submitted.

4. Notice of Additional Information submitted by the Requestor is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: Letter dated 07/23/02

   "SOAH decisions say if the carrier doesn't care to respond then they lose their opportunity to put in a reason. If no reason is put in by carrier as to the denial the provider 'should' win if the MDR reviewer follows TWCC rules."

2. Respondent: There was no response found in the case file.

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only dates of service eligible for review are those commencing on 08/06/01 through 01/22/02.

2. Some EOBs were submitted with the denial codes of "A-PREAUTHORIZATION NOT OBTAINED. F-FEE GUIDELINE MAR REDUCTION."

3. With no EOBs, charges for the DOS in dispute will be decided as a Fee Dispute.

4. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT or Revenue CODE	BILLED	PAID	EOB Denial Code(s)	MAR$	REFERENCE	RATIONALE:
09/10/01 (1 unit) 09/12/01 (1 unit) 01/15/02 (1 unit)	97122	$35.00 $35.00 $35.00	$0.00 $0.00 $0.00	No EOB No EOB A	$35.00 (per 15 minutes)	TWCC Rule 134.600(h)(10) MFG MGR (I)(A)(10) CPT descriptor	The provider billed CPT code 97122 in accordance with the Fee Guidelines. "Procedures (Supervision by the doctor or HCP, in either a group (97150) or one-to-one (97110-97139) setting is required." The notes are descriptive of modalities performed, length of procedures, and response from injured worker on how the therapy session helped the claimant. However, the SOAP notes do not support any clinical (mental or physical) reason as to why the patient could not have performed his exercises in a group setting, with supervision, as opposed to one-to-one therapy. Recent review of disputes involving CPT Code 97122 by the Medical Dispute Resolution Division indicate overall deficiencies in the adequacy of the documentation of this code. The disputes indicate confusion regarding what constitutes "one-on-one." The Medical Review Division has reviewed the matters in light of all of the Commission requirements for proper documentation and concludes, there is insufficient documentation to allow reimbursement beyond one unit on each date of service. It would appear logical to reimburse 1 unit of a 1-1 code in order for the therapist to instruct the claimant on the exercise and to make sure that the claimant is doing them correctly. Therefore, reimbursement for the DOS 09/10/01 and 09/12/01 is recommended in the amount of **$75.00**. ($35.00 x 2). For the date of service 01/15/02 denied "A", the CPT code does not require preauthorization. Therefore, reimbursement in the amount of **$35.00** is recommended. Medical documentation indicates that the services were rendered and billed according to the CPT descriptor. Therefore, reimbursement is recommended in the amount of **$105.00**. ($35.00 x 3).

08/29/01 08/30/01 09/12/01 01/15/02	97110	$105.00 $105.00 $105.00 $105.00	$0.00 $0.00 $0.00 $0.00	No EOB No EOB No EOB A	$35.00 (15 minutes)	MFG MGR (I)(A)(10) CPT descriptor	"Procedures (Supervision by the doctor or HCP, in either a group (97150) or one-to-one (97110-97139) setting is required." The notes are descriptive of modalities performed, length of procedures, and response from injured worker on how the therapy session helped the claimant. However, the SOAP notes do not support any clinical (mental or physical) reason as to why the patient could not have performed his exercises in a group setting, with supervision, as opposed to one-to-one therapy. Recent review of disputes involving CPT Code 97110 by the Medical Dispute Resolution Division indicate overall deficiencies in the adequacy of the documentation of this code. The disputes indicate confusion regarding what constitutes "one-on-one." The Medical Review Division has reviewed the matters in light of all of the Commission requirements for proper documentation and concludes, there is insufficient documentation to allow reimbursement beyond one unit on each date of service. It would appear logical to reimburse 1 unit of a 1-1 code in order for the therapist to instruct the claimant on the exercise and to make sure that the claimant is doing them correctly. Therefore, reimbursement for the DOS 08/29/01, 08/30/01, and 09/12/01 is recommended in the amount of **$105.00**. ($35.00 x 3). For the date of service 01/15/02 denied "A", the CPT code does not require preauthorization. Therefore, reimbursement in the amount of **$35.00** is recommended. Medical documentation indicates that the services were rendered and billed according to the CPT descriptor. Therefore, reimbursement is recommended in the amount of **$140.00**. ($35.00 x 4).
08/06/01 08/20/01 09/04/01 01/22/02	95851	$72.00 $72.00 $36.00 $72.00	$0.00 $0.00 $0.00 $0.00	F F F F	$36.00 Per body area)	TWCC Rule 134.304(e) MFG MGR (I)(A)(10) CPT descriptor	The Carrier's denial does not conform with TWCC rule 133.304(c) that states, "A generic statement that simply states a conclusion such as 'not sufficiently documented' or other similar phrases with no further description of the reason for reduction or denial of payment does not satisfy the requirement of this section." The provider billed CPT code 95851 in accordance with the Fee Guidelines. Therefore, reimbursement is recommended in the amount of **$252.00**.

08/29/01 08/30/01 09/12/01 01/15/02	97265	$43.00 $43.00 $43.00 $43.00	$0.00 $0.00 $0.00 $0.00	No EOB No EOB No EOB A	$43.00	MGR (I)(A)(10); CPT Descriptor TWCC Rule 133.304(c)	Medical documentation indicates that the services were rendered and billed according to the CPT descriptor. Therefore, reimbursement is recommended for the dates of service 08/29/01, 08/30/01, and 09/12/01in the amount of **$129.00**. For the date of service 01/15/02 denied "A", the CPT code does not require preauthorization. Therefore, reimbursement in the amount of **$43.00** is recommended, bringing the total amount of reimbursement to **$172.00.**
08/30/01 09/12/01 01/15/02	97250	$43.00 $43.00 $43.00	$0.00 $0.00 $0.00	No EOB No EOB A	$43.00	MGR (I)(A)(10); CPT Descriptor TWCC Rule 133.304(c)	However the Carrier's denial does not conform with TWCC rule 133.304(c) that states, "A generic statement that simply states a conclusion such as 'not sufficiently documented' or other similar phrases with no further description of the reason for reduction or denial of payment does not satisfy the requirement of this section." Medical documentation indicates that the services were rendered and billed according to the CPT descriptor. Therefore, reimbursement is recommended in the amount of **$172.00**.
08/29/01 08/30/01 09/12/01	99213-MP	$48.00	$0.00	No EOB No EOB No EOB	$48.00	MFG E/M GR (IV)(C)(2) CPT descriptor	E/M GR indicates the appropriate level of service is based on; **"...TWO OF THE THREE KEY COMPONENTS** (as set out in the descriptors) shall meet or exceed the stated requirements to qualify for a particular level of E/M services: office, established patient; ..." and " Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of the three key components: an expanded problem focused history; an expanded problem focused examination; medical decision of low complexity." Documentation indicates that the manipulations were rendered. Therefore, reimbursement is recommended in the amount of **$48.00.**
12/20/01	99213	$48.00	$0.00	No EOB	$48.00	MFG E/M GR (IV)(C)(2) CPT descriptor	E/M GR indicates the appropriate level of service is based on; **"...TWO OF THE THREE KEY COMPONENTS** (as set out in the descriptors) shall meet or exceed the stated requirements to qualify for a particular level of E/M services: office, established patient; ..." and " Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of the three key components: an expanded problem focused history; an expanded problem focused examination; medical decision of low complexity." Documentation indicates that the services were rendered and billed according to the MFG. Therefore, reimbursement is recommended in the amount of **$48.00**.
Totals		$1,270.00	$0.00				The Requestor **is** entitled to reimbursement in the amount of **$937.00.**

V. ORDER

Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Medical Review Division hereby ORDERS the Respondent to remit $937.00 plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this order.

This Order is hereby issued this 3rd day of December 2002.

Michael Bucklin
Medical Dispute Resolution Officer
Medical Review Division

MB/mb